***California Health Policy and Data Advisory Commission***
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**Minutes**
**California Health Policy and Data Advisory Commission**
**February 23, 2007**

The meeting was called to order by Vito Genna, Chair, at approximately 9:00 a.m., in the Crown Plaza Hotel at the Los Angeles International Airport. A quorum of half of the members plus one was in attendance.

| **Present:** | **Absent:** |
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| Vito J. Genna, Chairperson | Janet Greenfield, RN |
| William Brien, MD | Sol Lizerbram |
| Marjorie Fine, MD | Kenneth M. Tiratira, MPA |
| Howard L. Harris, PhD | Corinne Sanchez, Esq. |
| Adama Iwu | |
| Jerry Royer, MD, MBA | |
| Josh Valdez, DBA | |

**CHPDAC Staff:** Kathleen Maestas, Acting Executive Director; Terrence Nolan, Office Manager

**OSHPD Staff:** David M. Carlisle, MD, PhD, Director; Elizabeth Wied, Chief Counsel; Michael Rodrian, Deputy Director, Healthcare Information Division; Joseph Parker, PhD, Health Quality and Analysis Division; Jonathan Teague, Manager, Healthcare Information Resources Center; Kenny Kwong, Manager, Accounting and Reporting Systems

Oath of Office: David M. Carlisle, MD, PhD, Director, OSHPD

Dr. Carlisle administered the oath of office to newly appointed Commissioner, Adama Iwu. Ms. Iwu came to Sacramento about one and one-half years ago on an Executive Fellowship in the Director's Office of the Department of Managed Healthcare, working on financial solvency, enforcement and legislation. This was a great introduction to healthcare and the underlying issues pertaining to managed care in the State of California.

Prior to that, Ms. Iwu was an Events Director working for a ministry for approximately five years, conducting mission trips all over the world. She has a Political Science

degree from the University of San Diego and is beginning her second year of Master's in Health Administration at USC. She currently is employed by the California Association of Physician Groups, working on legislation and policy.

Approval of Minutes: A motion was made, seconded and carried to approve the minutes of the December 8, 2006 meeting.

Chairman's Report: Vito Genna, Chair

At the last meeting, the former Executive Director of the Commission gave a historical perspective of the Commission, which is included in the December minutes.

For the new Commissioner's benefit, Mr. Genna summarized the committees.
Dr. Jerry Royer is Chair of the Technical Advisory Committee, which works on risk-adjusted outcome studies. An Appeals Committee, which rarely meets, hears appeals of facilities that have been fined for late submission of reports. The Health Data and Public Information (HDPIC) is chaired by Dr. Howard Harris. This committee is composed of members on the medical records and consumer side and delves into more detail concerning the data collected by OSHPD, balancing it as far as the data that is needed and the cost factor for hospitals and long-term care facilities incurred in obtaining that data. Commissioners are welcome to attend any of the committee meetings.

Chairperson Genna reported that he was in Sacramento in early February meeting with the Aging Services of California, which represents the nonprofit, long-term care side of nursing homes and retirement communities. Discussions were held with several legislative aides. At the end of the meeting, Chairperson Genna asked if they were aware of the Perspectives in Healthcare publication recently released by OSHPD and was disappointed to hear they were not aware. He was told that legislators receive numerous publications on healthcare every day. Chairperson Genna suggested that perhaps OSHPD could reevaluate how the publication is released to differentiate it as a valuable resource. Deputy Director Rodrian said this publication was personally delivered as opposed to mailing it. This is something that can be discussed by HDPIC.

OSHPD issued a press release for a report on community-acquired pneumonia hospital outcomes in California, 2002-2004. This report includes two risk-adjusted models, one containing the do-not-resuscitate (DNR) variable and one excluding the DNR variable. If hospitals are outliers on both models, only then are they designated as an outlier in the report.

Commissioner Valdez of volunteered to issue a press release and link to this information to the internet, which could potentially reach 8 million members.

OSHPD Director's Report: David M. Carlisle, MD, PhD, Director, OSHPD

Dr. Carlisle announced the appointment of Patrick Sullivan as Deputy Director of Public and Legislative Affairs, filling the vacancy created when Teresa Smanio retired. Mr. Sullivan came from the office of former Assembly Member Richmond, and is very well

versed on health policy issues. Dr. Carlisle said he wanted to publicly thank Teresa Smanio for her contributions to OSHPD.

Ruben Jimenez, Deputy Director of Administration, left OSHPD to take a substantial CEA level promotion with the Department of Water Resources. Many senior executives within State Government are retiring, and there are rapidly accelerating promotional pathways upon their departures from Civil Service.

Governor Schwarzenegger recently appointed Mr. Sarmiento to the position of Appointments Secretary within the Governor's Office.

There are currently two important vacant positions within OSHPD that are being filled in an interim or acting capacity: The Executive Secretary for the Health Policy and Data Advisory Commission has been filled by Kathleen Maestas for almost two years in an acting capacity. The Executive Director position with the Health Professions Education Foundation is being filled in an interim capacity by Stephanie Clendenin, who is also filling in as Acting Deputy Director for Administration.

Dr. Carlisle talked about OSHPD's role in healthcare reform. OSHPD is in the process of implementing a reassessment of the seismic risk of California hospitals, using a FEMA-based software program called HAZUS. The previous assessment technology was about 15 or 20 years old. HAZUS will assess the risk of ground motion in an area, and will not just be looking at hospital structure, but can predict damage and fatalities from earthquakes, and has been used in many areas. OSHPD has authority to generate intermediate deadlines for HAZUS-related performance changes, as long as the 2030 deadline is not exceeded. There is sufficient regulatory authority to carry out the use of HAZUS. The cost of seismic safety repairs will translate into increased costs for healthcare in California. The cost of seismic safety is hard to separate from the cost of modernizing obsolete hospital structures.

The Song-Brown Program recently awarded over $3 million to various nursing education programs. Historically, this program has supported education of family practice physicians, family medicine, nurse practitioners, and family medicine physician assistants.

Dr. Carlisle encouraged Commissioners to attend the Senate budget hearings to be held on March 8.

<u>Presentation on Governor's Healthcare Proposal</u>: Dr. Carlisle

The Governor's healthcare proposal contains multiple components that rely on each other to sustain the whole. Different stakeholders would have shared responsibility and shared benefit. In the past, California has tried employer mandated healthcare reform, single payer healthcare reform, and pay or play healthcare reform; none of these have succeeded. The Governor's proposal contains elements of each and is promoting prevention (e.g., obesity, tobacco cessation) and healthcare information technology.

The Medi-Cal and Healthy Families programs will be expanded, of which some financing will come from providers and Federal Government.

Transparency in healthcare is designed to shift services away from expensive, poor outcome providers to providers that are less expensive and have better outcomes. This is where OSHPD's outcomes program comes into play.

Approximately 65 emergency rooms have closed during the past decade, mostly because the whole hospital closed or just the ER section because of the cost of emergency rooms. The number of emergency room beds in operation in California has stayed about the same, despite the closures of emergency rooms. The ERs are seeing increased numbers of urgent and near-urgent cases; the number of non-urgent care has decreased in California emergency rooms.

The chief consultants of this healthcare reform plan are: Herb Shultz, formerly with the Department of Managed Healthcare, who is very familiar with operational aspects of health plan operations and underwriting. John Ramey was the founding executive for MRMIB, and is an expert on underwriting, health policy, and health plan operation. Richard Figueroa has been very involved in health policy in California. Ruth Liu from Kaiser Permanente has expertise in health plan operations, and is an underwriting and actuarial expert.

Health Data and Public Information Committee (HDPIC) Report: Vito Genna

In the absence of Dr. Harris, Vito Genna chaired the HDPIC meeting held on January 24, 2007. The Committee discussed the pricing regulations, viewing the Chan Bill from more of a consumer perspective. The law only calls for hospitals to submit operational policies to OSHPD, which will be displayed in an easy-to-read fashion. The law differentiates that OSHPD is merely the collector of these policies, and enforcement will be conducted by the Department of Health Services. The Committee indicated that it would have preferred a standardized format so that information could be put in a matrix or grid form from which data could be easily extracted for comparison.

There was some concern that if it is shown that certain hospitals are giving better charity care, and that there might be a new demand for hospitals that are more liberal with their charity care. There was much concern about whether DHS, the investigative arm of hospitals, will be checking for accuracy of the information reported to OSHPD.

At the meeting, there was also a presentation on additional clinical and lab values, which could potentially be added to the discharge data set. The medical records members of the Committee did not see a major cost issue with adding the information.

Technical Advisory Committee: Jerry Royer, MD, MBA, Chair

The TAC meeting covered the validation project, looking at the patient discharge data, the revised acute myocardial infarction (AMI) report model, the maternal outcomes report, and the expansion of the patient discharge data set.

The contractor presented a validation report on the value of adding condition present at admission (CPAA), do-not-resuscitate order (DNR) and injuries, or E-codes to the models. This project began about eight months ago and will continue through the end of 2007.

The first area of validation, condition present at admission, determines those conditions at admission versus complications that occur after admission, which may relate to quality of care problems. California and New York are the only states that have included CPAA in its models. New York added this code in 1994, and California began using the code in 1996. Beginning in October 2007, all hospitals have been mandated to include CPAA.

The coding accuracy of CPAA varies. The question is whether hospitals may choose to over-code CPAA, which increases the acuity level and would help to diminish the mortality figures.

The second area of validation, do-not-resuscitate (DNR), is important in risk adjustment because it has been found that DNR is associated with a higher mortality rate. There is also much variation in coding among hospitals. It was thought that hospitals might possibly try to game the system by over-reporting in a way that death would not be included in the hospital's mortality rate. OSHPD's definition of DNR is that the order has to occur within 24 hours of admission.

The third area of validation is injury, or E-codes. This would include where the injury or accident happened so this data could be used for public health measures and public health assessments.

Reabstracting will be on all data elements, 2,250 records, on ten percent of the hospitals, looking at some umbrella conditions of AMI, community-associated pneumonia, congestive heart failure, and PTCA (angioplasty).

A proposed model for risk adjusting AMI was presented. The contractors used literature and expert advice and focused on acute risk factors. The original model used 24 different variables and 30 different interrelated variables. The question is whether the 30 interactive variables add that much more to the risk adjustment. The contractors are recommending the use of the principle of parsimony (describing something with a smaller number).

The next agenda item was maternal outcomes, measuring outcomes of perineal lacerations for vaginal deliveries and readmission within 30 days. There is not much of a volume/outcome relationship for maternal outcomes. The contractor looked to determine if there is a bias from the choice of mode of delivery, vaginal or cesarean delivery. It was suggested hospitals are not doing that and there is no bias in mode of delivery. It was noted that the practicality of expectant mothers traveling long distances to other hospitals was not very likely because of the geography in California.

The intent of the analysis was to determine whether or not to exclude small volume hospitals from public reporting because of the unreliability of their risk-adjusted outcomes. If there was a volume/outcome relationship, which meant that small volume

hospitals were possibly doing a poorer job, then they should not be excluded from reporting. Smaller hospitals cannot be in the better than expected or less than expected outlier classifications.

The last agenda item was expanding the patient discharge data set. Legislation allows OSHPD to add 15 data elements over a five-year period. It was thought that clinical elements would strengthen the outcomes projects. The Bindman report to OSHPD was presented, with suggested lab values, demographic items, and vital signs. Dr. Bindman suggested that OSHPD might want to wait until another report by Michael Pine and Associates is released. The Pine report was not available when Dr. Bindman completed his report. It was suggested that staff invite Dr. Michael Pine and Dr. Bindman to a meeting to discuss the two reports.

There was some frustration voiced by the TAC members about (1) the infrequency of the TAC meetings during the past few years and use of their expertise, and (2) the fact that the legislation was passed ten years ago to add to the discharge data set and still have not been accomplished. The TAC members have been anxious to develop models using clinical and other types of data.

OSHPD would be asking providers to collect new categories of variables from different sources, some of which may not exist, apart from the medical record and OSHPD wants to be sure that the reporting burden concerns for providers are addressed.

There was a recommendation for OSHPD to develop a short list of potential data items.

The TAC meeting concluded without discussing the Community-Acquired Pneumonia report using 2002-2004 data and the surgeon level CABG report.

A motion was made, seconded, and carried by CHPDAC that the TAC and HDPIC Committees meet jointly to discuss the additional data elements.

Dr. Parker next presented some information about the Pine report which was given to him in advance of publication.

There is a large list of potential data elements to add to the patient discharge data set. OSHPD focused on data elements already being collected by hospitals and which were automated, such as lab values. There are nationally standardized reporting formats that are available for most hospitalized patients. OSHPD will not recommend that these be collected on all hospitalized patients, only hospitalized patients for whom it would be reasonable to collect this data and for which there is an indication of need.

Question was asked as to the most effective clinical data elements that could be added to existing administrative data systems. Dr. Pine used extensive clinical data collected in Pennsylvania, combining that with administrative data. The data were examined for eight patient cohorts in that there are different ways to look at this data. Dr. Pine also looked at some risk-adjusted complications for the ARC patient safety indicators.

The selected conditions were abdominal aortic aneurism repair, AMI, CABG, congestive heart failure, craniotomy, GI hemorrhage, pneumonia and stroke. OSHPD is either currently reporting on some of these conditions or is planning to report in the future on them. There were about 700,000 patients and 200 hospitals included in the study, using seven different risk models. A version of CPAA was created and added to the standard administrative dataset as well as lab values and vital signs. Beyond that, they added composite clinical measures and looked at about 50 clinical risk factors. About five different vital signs were tested in the models. The performance was evaluated by predicting mortality. The model costs were evaluated, using estimates of data reabstraction times for different classes of personnel within the hospital. They valued the cost effectiveness by comparing the differing reabstracting costs with the improvements in the prediction of individual patient outcomes relative to a clinical gold standard.

Some of the highlights from the findings are: There was a large increase in performance when the CPAA code was added to the basic administrative data model. The admission vital signs were relatively unimportant risk factors of risk predictors after lab values had been added. The difficult-to-collect composite clinical measures did little for improving the predictive performance of the models.

The basic finding was that the addition of a limited set of values helped a CPAA- based risk model increase its performance sufficiently to support stratification of surgical mortality for those conditions.

Dr. Parker then showed a listing of data elements which Dr. Jennifer Haas had developed in a previous study, where there was overlap with Dr. Bindman's recommendations and those derived from the Pine report. Dr. Hass was most interested in predicting AMI, pneumonia, CHF and ICU patient outcomes. Some of the data elements are bundled and typically are reported together such as hematology and chemistry values.

After the data elements are selected, OSHPD will need to go through the regulatory process. OSHPD's Patient Discharge Data Section is unable to state a date for addition of the data elements because there is a possible move to ICD-10 in the very near future. Anytime a change is made to the system, it is expensive and involves contracting. There is a question of how many data elements can be added over a given period and some of the data elements recommended by Dr. Bindman were not recommended by others. The real question is what elements will give the most return for the work being done, and are easily accessible. Chairperson Genna asked that the TAC and researchers knowledgeable in how the risk-adjustment models work should generate a rank order of which variables are most germane to the work being done by OSHPD and present this information.

<u>AB 774 Regulation package (Hospital Fair Pricing Policy)</u>: Kenny Kwong, Manager, Accounting and Reporting Section

This legislation affects all hospitals that are licensed under Sections 1250 (a), (b) and (f), about 380 general acute care hospitals, 30 psychiatric acute hospitals, and one specialty hospital, a hospice and palliative care facility. The intent of the statute is to regulate

hospital charges and their collection procedures for the uninsured and the under-insured by increasing public awareness of the availability of charity care in government and also by standardizing the billing and collection procedures of hospitals. Information about the policies must be posted in a clear and conspicuous location such as emergency room, admitting office, billing office and other outpatient locations.

Information about the policies must be provided whenever a patient is admitted and when they are billed. The policies and related documentation must be language appropriate and provided in native languages if more than five percent of the persons served do not speak English, or do not communicate effectively in English because it is not their native language.

The enacting legislation did not speak to patients covered or what services are covered. It did not specify a floor at which free charity care must be provided and did not specify what level of the Federal Poverty Level that the hospital should use in order for a patient to qualify. It also does not specify what types of income could be used for determination.

At the HDPIC meeting, the representative from the California Hospital Association mentioned there would be clean-up legislation introduced which will clarify some of these items.

Information on the following must be submitted to OSHPD: charity care and discount payment policies, eligibility procedures for those policies, internal review process that a hospital would use to determine eligibility, and the application form that patients fill out to determine if they qualify. OSHPD will be collecting this information electronically and is developing a more consumer friendly website.

The HDPIC members recommended adding a definition for a discount payment to clarify that the discount payment relates to partial payment and charity care.

Mr. Kwong outlined the regulations and timelines in more detail. At upcoming meetings, staff will display some prototypes of what hospitals will see when they submit the documents to OSHPD.

A motion was made, seconded and carried to adopt the proposed regulations.

Next Meeting: The next meeting will be held on April 20 in Northern California.

Adjournment: The meeting adjourned at 12:20 p.m.

Pending Items:

1. Hold joint meeting of TAC and HDPIC committees to discuss expansion of the data elements and to review the Pine and Bindman reports in order to bring forward a recommendation to CHPDAC.

2. Chairperson Genna requested that emergency room and hospital closure data be presented to the CHPDAC and Deputy Director Rodrian agreed that the information was available.

3. Commissioner Royer inquired into an expanded presentation on the two models used in the recently released Community Acquired Pneumonia Report, one containing the DNR variable and the other not containing the DNR variable.